Fertility Within Reach
ADVOCATING FOR FERTILITY HEALTH CARE

Co-Chairs Gilchrest and Lesser
Human Services Committee
Legislative Office Building, Room 2000
Hartford, CT 06106

Re: Raised bill 6617 AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE

Dear Co-Chair Gilchrest, Co-Chair Lesser, and Members of the Human Services Committee,

I hope this letter finds you well. My name is Davina Fankhauser, and I am the Co-Founder of Fertility Within Reach, a national nonprofit advocating for fertility healthcare and currently serve as President of the New England Fertility Society. I am a member of the American Bar Association Family Law Legislative Committee and write fertility legislation throughout the United States. I have been directly involved in passing legislation throughout New England, including CT in 2005, and working with Melissa Thompson in 2017 to pass Melissa's Law. I also serve as an expert for actuary reports related to the cost of fertility healthcare. For the past four years, I have been part of a CT advocacy group known as Affordable Families. We wrote the majority of the legislation you are voting on today. Our bill, which sought equity in fertility care, was edited to include Medicaid, which I can support, but also includes language I believe can unintentionally limit fertility healthcare. Today, I am asking you to act to amend Raised bill 6617.

There are several sections I would like to bring to your attention. I will share the language of the bill, followed by my comments.

Sec. 2 (b) …January 1, 2024, shall provide coverage for:
(1) Fertility diagnostic care;
(2) Fertility treatment <u>if the enrollee is a fertility patient</u>; and
(3) Fertility preservation services.

A "fertility patient," as defined in this bill, would extend to "(A) an individual or a couple experiencing infertility, (B) an individual or a couple who is at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child, (C) an individual unable to achieve a pregnancy as an individual or with a partner because the individual or couple does not have the necessary gametes to achieve a pregnancy, or (D) an individual or couple for whom fertility preservation services is medically necessary." While we appreciate language to clarify who a fertility patient is, it does not include a third-party patient for the benefit of an enrollee. In Massachusetts and Rhode Island, IVF benefits extend to third-party involvement (donor egg, donor sperm, donor embryo) for the benefit of the enrollee.[1,2] IVF that involves a gestational carrier surrogate is another form of third-party healthcare. IVF utilizing third-party reproduction for the enrollee's benefit is a standard healthcare option for patients with this

need and has approximately the same cost as IVF without third-party.[3]

I ask you to consider changing Sec. 2 (b) (2) from "(2) Fertility treatment if the enrollee is a fertility patient; and" to "(2) Fertility treatment; and". Another option would be to further define "fertility patient" to include "an individual receiving fertility treatment for the benefit of the enrollee."

Further, Sec. 2 (c) (4) reads, "(c) A policy that provides coverage for the services required under this section, may not: (4) Impose any limitations on coverage required under this section based on an individual's use of donor gametes, donor embryos or surrogacy. " While I appreciate that this language attempts to prevent discrimination against a fertility patient using donor gametes, donor embryos, or gestational carrier surrogates, the language does not ensure treatment coverage for the third-party patient.

Sec. 2 (e) (3) was added, but conflicts with section (i). Specifically,

"(e) A policy that provides coverage for the services required under this section may: (3) Limit coverage for in-vitro fertilization to those individuals who have been unable to achieve or sustain a pregnancy to live birth through less expensive and medically viable infertility treatment or procedures covered under such policy; and"

This language is unnecessary and conflicts with language in Sec. 2 (i). I would recommend eliminating Sec. 2 (e)(3).

Sec. 2 (i) reads, "Nothing in this section shall be construed to deny the coverage required under this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful or the individual seeks to use previously retrieved oocytes or embryos."

The last part of (i) includes unnecessary language and supports an existing problem with insurance companies. Insurers can require patients to transfer previously retrieved oocytes or existing embryos before covering a fresh IVF cycle. This includes embryos that are poorly graded and not likely to result in a live birth. Eliminating the final part of the sentence "or the individual seeks to use previously retrieved oocytes or embryos" will allow doctors to proceed with a fresh IVF cycle if it saves time and cost and, most importantly, optimize healthcare. The suggested revised language for (i) would read: "(i) Nothing in this section shall be construed to deny the coverage required under this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful."

The original intent of our bill was to bring equity to fertility healthcare, not only in terms of socio-economic status but for those currently paying premiums for coverage and are denied benefits. We wanted to ensure no one was discriminated against as they sought medical care to have a family. Sadly, we see this happening with individuals denied benefits based on age or

sexual orientation. While I am glad to see language providing benefits to those with financial need, we are missing the big picture of equity in fertility healthcare if same-sex couples and individuals cannot access coverage for healthcare they pay for in their premiums. I would encourage a change to the "Statement of Purpose" to read: "To provide equitable health insurance coverage for fertility health care."

With nearly twenty years of working on fertility legislation, I have found language is critical to close insurance loopholes that will deny and ultimately delay reproductive healthcare. Fertility treatment is time sensitive, and sometimes facing an insurance appeal is enough to lose an opportunity to have a family. If we start with the best possible language in statute, we can prevent burdening the Insurance Department later. I appreciate your consideration of amending HB6617.

Sincerely yours,

Davina Fankhauser
Co-Founder & Executive Director
Fertility Within Reach
President, New England Fertility Society
Mobile: 857-636-8674
Email: admin@fertilitywithinreach.org
Website: www.fertilitywithinreach.org

References

Blue Cross Blue Shield of MA. Medical Policy Assisted Reproductive Services, Policy Number: 086. https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/086%20Assisted%20Reproductive%20Services%20Infertility%20Services%20prn.pdf

Blue Cross Blue Shield of RI. Medical Coverage Policy. Infertility Services https://www.bcbsri.com/providers/sites/providers/files/policies/2022/09/2022%20Infertility%20Services_1.pdf

American Society for Reproductive Medicine. Practice Committee Documents.
Recommendations for practices using gestational carriers: a committee opinion (2022)
Repetitive oocyte donation: a committee opinion (2020)
https://www.asrm.org/news-and-publications/practice-committee-documents/